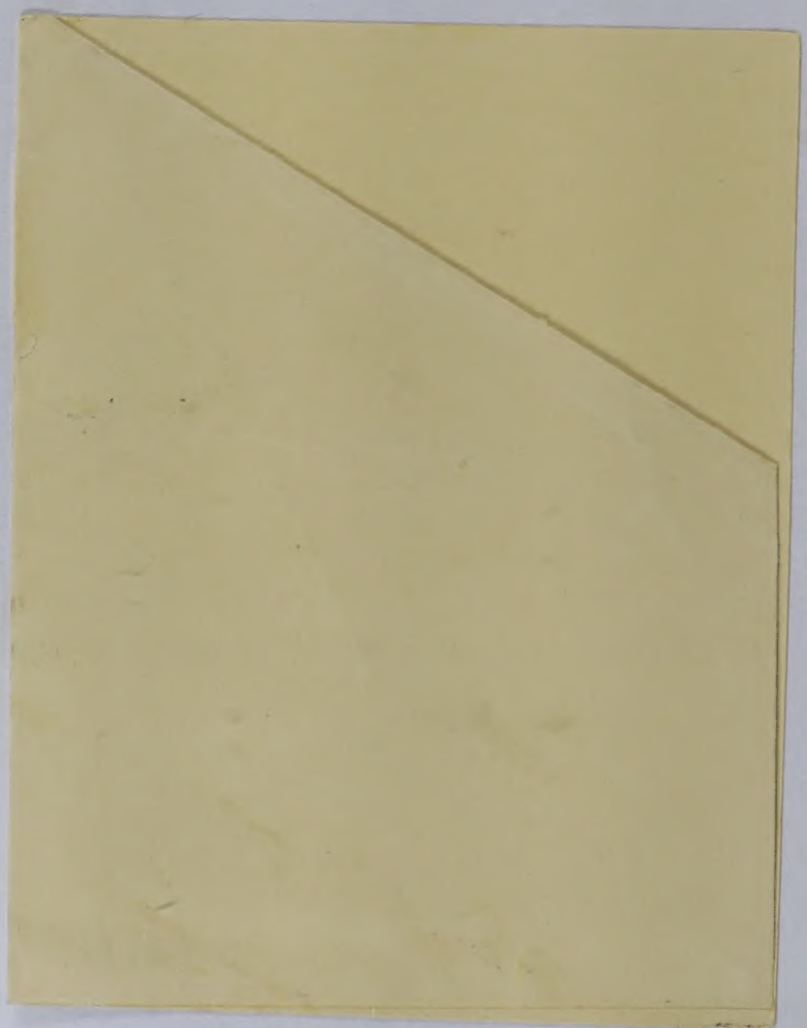
NATIONAL MENTAL HEALTH PROGRAMME FOR INDIA



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NATIONAL MENTAL HEALTH PROGRAMME FOR INDIA

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INTRODUCTION

Health has been defined as a positive sense of well-being—physical, mental and social—and not merely an absence of illness. Mental Health thus is an integral component of total health. It must, therefore, occupy its rightful place in the national health policy. Government of India, therefore, felt the necessity of evolving a plan of action aiming at the mental health component of the national health programme and for this, an Expert Group was formed in 1980.

This Group met a number of times and had discussion with many of the important persons concerned with mental health in the country as well as with the Director, Division of Mental Health, W.H.O.; Geneva. Finally, in February, 1981 a small drafting committee met in Lucknow and prepared the first draft of National Mental Health Programme for the country. This was presented at a "Workshop" of experts on mental health drawn from all over India at New Delhi in July 1981. Following the discussion the draft was considerably revised and the new draft was presented at the second workshop in August 1982 to a group of experts belonging not only to psychiatry and medical profession but also to education, administration, law, social welfare, etc.

The final draft was submitted to the Central Council of Health, the country's highest health policy making body at its meeting held on 18—20 August, 1982 for adoption as National Mental Health Programme for India. The Council discussed this programme at length and adopted a resolution for implementation in the states and Union Territories of the country.

This document is the result of the dedicated efforts put in by a large number of mental health professionals of our country as well as by Directorate General of Health Services and Ministry of Health and Family Welfare, Government of India. Equally valuable has been the contributions of the staff of the World Health Organization particularly the Adviser in Mental Health, Regional Office for South-East Asia [S.E.A.R.O.] New Delhi.

We believe and hope that this National Mental Health Programme would serve the following objectives:

i. To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of population;

ii. To encourage application of mental health knowledge in general health care and in social development;

iii. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

We also believe that this Programme would serve as a guide for preparation of national programmes in mental health in other developing countries of the world.

D.B. BISHT
Director General of Health Services

NATIONAL MENTAL HEALTH PROGRAMME FOR INDIA

1. INTRODUCTION

India is a signatory State to the Alma Ata Declaration which envisages health for all by the year 2000 as the goal. Efforts to ensure the achievement of this goal will have to include approaches and strategies for the improvement of all aspects of health—physical, mental and social. While the Government of India is fully seized with the formulation of a national health policy since mental health forms an integral part of total health, a plan of action aiming at the mental health component of the national health programme, needs to be put forward.

The importance of mental health cannot be over emphasized in the national health planning. The scope of mental health is not only confined to the treatment of some seriously mentally ill persons admitted to mental hospitals but it relates to the whole range of health activities. Man is essentially a thinking and feeling being. No scheme of health planning can be complete which does not take the mental health component into account.

In the past, mental health did not find its appropriate place in the national and state health planning perhaps due to a common misconception that prevalence of mental illness is low in India particularly as compared to the West. In addition, it was also thought that no effective treatment is available.

Research studies from different parts of the country have shown that mental illness is as common in India as it is elsewhere and is equally common in rural and urban areas. Mental illness causes immense suffering to the affected individual and his surrounding, although this suffering may not be clearly visible to others.

Following major scientific discoveries in the field of psychotropic drugs, physical methods of treatment, psychotheraphy and other behaviour modification techniques, simple, effective and cheap methods of treatment are now available for a large number of serious and disabling mental disorders. Further, it has been proven in many countries including India, that effective treatment can be delivered, for a certain range of disorders, without having to rely solely on doctors/psychiatrists.

Just as modern scientific knowledge can help us to prevent and treat disabling mental illnesses, the mental health skills can be used to improve the quality of general health services. There is good evidence to say that about 15–20% of all patients who seek help in general health services both in developed and developing countries, do so for emotional and psycho–social problems. Current medical mehods of dealing with these problems by unnecessary investigations and costly medicines are not only inadequate and ineffective but produce widespread frustration to both the seeker and the provider of these health services.

Mental health principles can improve the current health delivery system and thus reduce the ever increasing threat of dehumanization of modern medicine so repeatedly talked about in all countries. The proper mental health inputs in general health programmes like family planning campaign, immunisations and nutrition educational programmes can and will enhance the acceptance of these health and welfare activites of the country, by the people.

In full accord with the national health policy of India, and in pursuit of the goal of Health for All by the Year 2000, it is now possible and feasible to draw a national programme which would not only provide a minimum mental health care to all at a reasonable cost but also aim at healthy psycho–social development of the people. The proposed plan would also ensure that the benefit of mental health services would reach those who need it most and also to our vast number of people living in rural areas and urban slums.

It is obvious that the implementation of the **National Mental Health Plan** will be possible only through a strong commitment of the Governments of the States as well as at the Centre and through dedicated endeavours by **not only all health personnel of all categories but also the personnel working in individual and integrated programmes of national development and by the active participation of the community.**

PLANNING MENTAL HEALTH SERVICES FOR THE COUNTRY

We have to take into account the following three aims:

1. Prevention and treatment of mental and neurological disorders and their associated disabilities.
2. Use of mental health technology to improve general health services.
3. Application of mental health principles in total national development to improve quality of life.

2. ANALYSIS OF THE PRESENT SITUATION: NEEDS, SERVICES AND FACILITIES

A wealth of information is available in India concerning the prevalence of mental disorders. According to most of the surveys about 10–20 per thousand of the population are affected by a serious mental disorder at any point in time (point prevalence).

This would constitute about 10 million citizens of India. The figures for neuroses and psychosomatic disorders are about two to three times higher, thus indicating that 20–30 million people may require our attention. Mental retardation is estimated at 0.5 to 1.0% of all children, while alcohol and drug dependence rates, though still low as compared to the world scene, reveal a disturbing rising trend in pockets, for example alcohol consumption in Punjab, use of narcotics and cannabis in urban student population of the country.

The main burden of psychiatric morbidity in the adult population consists of:

[1] Acute mental disorders of varying etiology like acute psychoses of schizophrenic, affective or of unknown etiology, paranoid reactions, psychosis resulting from cerebral involvement in communicable diseases like malaria, typhus or bacterial meningitis, alcohol psychosis, and epileptic psychosis. These conditions usually lead to temporary disability but they cause much distress, and they can evolve into chronic disability if not properly treated.

[2] Chronic or frequently recurring mental illnesses, like some cases of schizophrenia and of periodic or cyclic affective psychosis, epileptic psychosis and dementias, encephalopathies associated with intoxications or chronic organic disease, etc. Modern treatment can achieve stable remissions, or reduce disability, in a significant proportion of these cases. Epilepsies constitute another important group of disease to be included here.

[3] Emotional illness such as anxiety, hysteria, neurotic depression are often associated with physical diseases. The majority of these patients would seek help at the general health services, but failure to recognise and treat the psychological component of their problem leads to prolonged distress and to unnecessary and wasteful prescriptions, investigations and referrals.

[4] Alcohol abuse, and alcohol and drug dependence appear to be growing problems, associated mainly with the new stresses of urbanization and industrialization, but their prevalence is also high in rural areas.

> The number of new cases of serious mental disorders which become manifest each year [incidence], can be estimated to be roughly 35 per 100,000 or about 2,50,000 in the country. With the methods for treatment and prevention available in modern health care, chronicity and disability can be avoided in about 80% of the cases. Complete and lasting recovery is possible in no less than 60%.

Reliable separate data on psychiatric disturbances among children especially learning and behaviour problems in school children do not seem to be available. However, there is evidence that their number is in the order of 1–2% of children. Similarly, psychiatric problems among older people especially in the large urban areas are assuming importance due to the weakening of the traditional family structure and social support systems.

No factual data are currently available regarding the loss of productivity, of income and even of life due to mental illness. But it should be pointed out that suffering due to mental illness often is not confined to the affected individual, but it causes severe social dysfunction of entire families.

2.1 Existing Mental Health Services

The presently available mental health facilities in India include about 20,000 beds in 42 mental hospitals and 2000 to 3000 psychiatric beds in general and teaching hospitals. For an estimated population of 680 million, there is one psychiatric bed per 32,500 population. Moreover, it is safe to assume that at least one half of these beds are occupied by long-stay patients adding to the shortage of active "treatment" beds. psychiatric units and mental hospitals operate out-patient clinics which are currently

the main source of mental health services in many cities. The number of specialized in-patient and out-patient facilities for children is insignificant. Self-help groups of parents with mentally retarded children exist in few cities only.

From the available data it is safe to conclude that not more than 10% of those requiring urgent mental health care are receiving the needed help with the existing services. The situation is worse in the rural areas due to the heavy concentration of the services and facilities in the cities. It is also to be noted that a simple extension of the present system of care also will not be able to ensure adequate services to the vast majority of our population in the near foreseeable future.

2.2 Manpower

The manpower includes approximately 900 qualified psychiatrists working in hospitals and having private practice, 400–500 psychologists, 200–300 psychiatric social workers and about 600 psychiatric nurses. Of the 108 recognised medical schools, only half have an academic department of psychiatry. There are only two dozen centres for post-graduate training in psychiatry with a total output of about 100 psychiatrists/year. It would be evident from the above that the psychiatric and para-psychiatric services in India are woefully inadequate. The problem is aggravated by the unequal distribution of psychiatrists with majority of them being concentrated in the urban areas. Hence, even with an increased rate of training of specialised staff, there is little hope to reach substantial portions of the rural population within the next two decades without major changes in the approach.

3. STRATEGIES FOR ACTION

In view of the gross disparities between needs and available services, there are essentially two approaches for immediate action. They are not alternatives since the difference between them lies mainly in the emphasis and in the level of priority assigned to different levels of service development. The first option would be to direct available resources to the establishment and strengthening of psychiatric units in all district hospitals. It would be hoped that these units would become foci of an expanding mental health service through setting up out-patient clinics and mobile teams. In general terms, the approach would be directed from centre to the periphery. In contrast, an alternative approach would be to train an increasing number of different categories of health personnel in basic psychiatric and mental health skills. There would thus be a functional infrastructure before completing, in all instances, a physical independent mental health infrastructure. The approach would basically be directed from the periphery to the centre.

This latter type of strategy would be truly innovative in as much as it would allow for a method of planning according to needs perceived at the grassroot level and it would allow for a speedy coverage of the hitherto under or unserved rural poor and other neglected sections of society within a reasonable period of time.

As pointed out above, these two strategic approaches are complimentary. Both will allow a private sector of mental health care to continue, **but in the second option the emphasis of the public sector will** be primarily directed towards the poor and the under-privileged. The programme, when in action, will directly benefit atleast 200

million population living in backward areas of the country. There will be no competition with the private sector nor will there be competition with psychiatric services and facilities existing in the cities. Of course, the services in the cities would continue to have a role as referral source, as well as centres of training and evaluative research.

Most mental health facilities in India actually function as passive recipients of patients. They become operational only where coping mechanisms in the community fail. The institutions have little knowledge and hardly any impact on these coping mechanisms as they exist and operate in the community. It is essential that the role of all mental health institutions in India becomes more active in concerning themselves with the social mechanisms involved not only in the development of mental illness but also in the more important issue of maintaining mental health.

4. OBJECTIVES

I. To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of population.

II. To encourage application of mental health knowledge in general health care and in social development.

III. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

5. APPROACHES TO THE STATEMENT OF PROGRAMME OBJECTIVES

In order to achieve the objectives formulated above, the programme will adopt the following approaches:

5.1 Difusion of mental health skills to the periphery of the Health Service System

This would mean that, instead of exclusively centralizing and concentrating mental health skills and expertise in specialized facilities, the capacity to provide mental health care will be spread over the existing network of services, with the aim to incorporate mental health awareness and skills at all levels of health care. Specifically this calls for reaching the periphery [i.e. the primary health care structure at the community level like the primary health centre, sub-centre and village health worker] in the performance of specified relatively simple tasks. Mental Health care thus must start at the grass-root level.

5.2 Appropriate appointment of tasks in mental health care

The tasks to be performed at each level [village workers, sub-centre, primary health centre, district hospital, regional hospital] will be specified, and a referral system set up so that the total system works in an integrated fashion.

The community health volunteer at the village level [approximately 1 worker for 1000 population] who is a community volunteer and only a part-time health worker, would be expected to act essentially as the liaison person between mental health caring system and the community. He will participate in case identification and

referral of patients, and will help to supervise follow-up of patients in need of longterm maintenance therapy. The multipurpose worker [M.P.W. one for a population of 5000] who is the first level full-time health personnel of our health service structure would act as the first link with health service system by providing first aid care and follow-up service. The senior and more experienced primary health care personnel [i.e. health supervisors, health inspectors, lady health visitors, etc.] would be entrusted with the task of early recognition and management of priority psychiatric conditions which he/she would carry out under the supervision of the medical doctor at the primary health centre. The medical doctor would have the overall responsibility of organising and supervising the primary level mental health care for the whole population under the jurisdiction of primary health centre or sub-centre. Details of the proposed activities for each level of health staff will be discussed below. The referral system will operate in a way which will make it possible that mental health problems are handled effectively at the appropriate level of the health system.

5.3 Equitable and balanced territorial distribution of resources

Coverage of unserved or under-served population will receive a high priority. Every effort will be made to introduce or strengthen mental health care first in those regions which are at present deprived of it or where it is seriously deficient.

5.4. Integration of basic mental health care into general health services

This will facilitate theapplicationof mental health skills when dealing with patients without gross psychiatric disturbances. It will also enable the health worker to identify psycho-social problems under the disguise of physical complaints and manage them more adequately. It will sensitize the primary health personnel of psycho-social factors contributing to ill-health and to human suffering.

5.5 Linkage to community development

An important approach would be the involvement of State, district and block leadership in the implementation of the mental health programme to ensure community involvement in preventive efforts directed at psycho-social problems like alcohol and drug abuse, behaviour problems of childhood and adolescence including delinquency, and other negative and eventually avoidable side products of rapid socio-economic change.

This need for linkages calls for further research into issues of psycho-social factors. It is also important for the future development, that linkages with other sectors of the community be fostered like with housing, education, town planning, legal agencies, to enhance the total mental health care awareness as well as for the application of mental health skills and knowledge for all persons.

5.6 Mental Health Care

The service component will include three sub-programmes-treatment, rehabilitation, and prevention.

[i] **Treatment.** The focus of the treatment sub-programme will be morbidity categories [1], [2] and [3], as outlined on pages 4 and 5. **Specified forms of treatment and** of diagnostic work will be implemented by personnel at the following levels of the regional health care system.

[a] Primary health care at the village and sub-centre level

Multi-purpose worker [MPW] and health supervisors will be trained to deal with the following problems within his own community under the supervison and support of the medical officer: [1] management of psychiatric emergencies [e.g acute excitement, crisis situations] through simple crisis-management skills and appropriate utilisation of specified medicines, [2] administration and supervision of maintenance treatment for chronic psychiatric conditions in accordance with guidance by the supervisors, [3] recognition and management of grandmal epilepsy [particularly in children] through utilization of appropriate medicines under the guidance of a medical doctor, [4] liaison with the local school techer and parents in matters concerning the management of children with mental retardation and behaviour problems, [5] counselling in problems related to alcohol or drug abuse. These tasks will be performed in accordance with simple operational instructions included in the MPW's manual. For each task, an appropriate difficulty/severity level will be specified, beyond which the problem would be automatically referred to the next level of health care.

[b] Primary Health Centre

The medical doctors aided by health supervisor will be trained to provide the following services: [1] supervision of the MPW's performances of specified mental health tasks, [2] elementary diagnostic assessment of cases, using diagnostic and management flow-charts, and performing a standardized basic neurological examination, [3] treatment of functional psychosis, [4] treatment of uncomplicated cases of psychiatric disturbance associated with physical diseases like malaria, typhoid, mild to moderately severe depressive states, anxiety syndromes and initial stages of functional psychoses with appropriate drugs, [5] management of uncomplicated psycho-social problems without the use of drug, [6] epidemiological surveillance of mental morbidity in the area and compilation of estimates of needs which would be submitted periodically to the next echelon for review and planning future services. In a way similar to the MPW's method of work, the medical officer will be guided by specified cut off points for referral of problems to a higher level of health service set-up.

[c] District Hospital

There is an urgent need for psychiatric specialists attached to every district hospital as an integral part of the district health services. The services provided will include [1] medical consultation to the health centre's medical officer with regard to "difficult" cases of psychiatric disorders, [2] admit and provide brief hospital treatment for psychiatric patients presenting with problems like severe excitement, refusal of food etc. needing ECT or higher doses of psychotropic medication for short periods of time or for complicated neurotic problems, and the district hospital should have the capacity to allocate at any time about 30–50 beds to patients with psychiatric indications for admission, [3] the district hospital would have linkage with state mental hospitals and teaching departments of medical college for further referral facilities.

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[d] Mental Hospitals and Teaching Psychiatric Units

These higher centres of psychiatric care will actively and dynamically function with links to the periphery. They will provide the necessary help for the care of the difficult patients and provide specialised facilities. Some of the facilities that are needed at this level are occupational therapy units, specialised psycho–therapeutic help like group therapy, marital counselling and behaviour therapy.

In addition to this traditional role of being advanced centres of care, the above centres will form the centre of all mental health educational effort. They will be training psychiatrists who will function as leaders of the mental health care programme. They will also be the ones to delineate the clinical details of the care programme.

This envisages a change in the role of the psychiatrist from a clinical specialist to a leader and planner of mental health services in his territory. He will devote only a part of his time to the clinical care of the patients, the greater part of his time being spent in training and supervising non–specialist health workers, who in turn will provide basic health care in the community. Thus, the training of specialists should include instructions and supervised experience in the areas of training and supporting non–specialist health staff. Most of the teaching psychiatric units both at general hospitals and mental hospitals are poorly equipped and staffed at present. The need for strengthening of those important components of support system is self–evident and should receive adequate support in the overall mental health programme.

[ii] Rehabilitation sub–programme

Rehabilitation of psychiatric patients will be facilitated greatly by maintenance treatment of epileptics and psychotics at community level. The counselling regarding principles of rehabilitation would be provided by the medical officer at primary health centre. Linkage with the services at district level psychiatric centre and state mental hospital would remain through referral system. Wherever practical, the rehabilitation centres would be developed at the district level as well as at the higher referral centres.

[iii] Prevention sub–programme

This component of the service programme will be community–based with only a limited involvement of the health service personnel. The main focus of the sub–programme in its initial phase will be the prevention and control of alcohol–related problems, with time experience and gain in credibility. However, it will be possible to expand its concerns to problems like addictions, juvenile delinquency, acute adjustment problems [e.g. suicidal attempts], and to an ability to articulate community mental health needs from the citizens' point of view. The main carriers of this sub–programme will be the medical officer and community leaders at the primary health centre levels.

5.7 Mental Health Training

Having accepted that mental health specialists like psychiatrists would not be enough in the near future in our country to deliver mental health care to all those who

immediately require it, we have to think in terms of alternative general health service cadres like general medical doctors and para-medical health workers, providing first level of care. As an immediate solution we will have to train as large a number of health personnel of all categories as possible in the minimum essentials of mental health tasks at their own level of performance as outlined above. However, for future investment we must give top priority to the better training of undergraduates-the future medical doctors.

Currently the amount and type of mental health training to medical undergrduates in our country is grossly inadequate [According to recent Medical Council of India's rules the obligatory psychiatric training during 5-1/2 years of undergraduate career is only 2 weeks at a psychiatric centre-which is usually at a distant mental hospital]. Thus the potential of using these future medical doctors as agents of a new and better mental health service system for our country as envisaged in these pages is seriously handicapped. At present 13,000 new doctors leave the portals of our medical colleges in every year. It is very important that the amount and content of training is quickly altered in such a manner that a newly qualified doctor is able to discharge his responsibility for better mental health care of the community. This single step, on implementation can become an important resource of all future mental health programmes.

Along with the better training of medical undergraduates, it is equally important to include essentials of mental health training in the teaching programmes of nurses, public health administrators and health staff or primary care system. Details of such training programmes for immediate action are given in the following chapter "Outline of the plan action."

5.8 Mental Retardation and drug dependence

Mental retardation is not mental illness but often associated with it as well as physical illness.

Often the mentally retarded first come to the notice of the medical services. The health workers therefore should be able to counsel the parents, provide public education in this subject as well as have the know-how to refer such children to approach social welfare agencies for rehabilitation. Simultaneously the Integrated Child Development Scheme [ICDS] personnel should be given the know-how to refer the mentally retarded recognised by them to medical agencies when indicated.

The group noted the formulation of a scheme under the VIth plan towards the problems of drug dependence and endorses the action taken in this regard.

6. OUTLINE OF PLAN OF ACTION

The plan of action aiming at achieving the above objectives will consist of a set of targets, and of detailed activities.

6.1 Targets

[a] Within one year each State of India will have adopted the present plan of action in the field of mental health.

[b] Within one year the Government of India will have appointed a focal point within the Ministry of Health specifically for mental health action.

[c] Within one year, a National Coordinating Group will be formed comprising representatives of all States, senior health administrators, and professionals from psychiatry, education, social welfare and related professions.

[d] Within one year, a task force will have worked out the outlines of a curriculum of mental health for the health workers identified in the different States as most suitable to apply basic mental health skills, and for medical officers working at PHC level.

[e] Within 5 years, at least 5000 of the target non-medical professionals will have undergone a 2-week training on mental health care.

[f] Within 5 years, at least 20% of all physicians working in PHC centres will have undergone 2 weeks training in mental health.

[g] Creation of the post of a psychiatrist in at least 50% of the districts within five years.

[h] A psychiatrist at the district level will visit all PHC settings regularly and at least once in every month for supervision of the mental health programme for continuing education. This programme will be fully operational in at least one district in every State and Union Territory, and in at least 1/2 of all districts in some States within five years.

[i] Each State will appoint a programme officer responsible for organization and supervision of the mental health programme within 5 years. Amongst other responsibilities for the programme, he will organize training courses in co-operation with the teaching institutions, and he will be the focal point of data gathering including evaluative data.

[j] Each State will provide additional support for creating or augmenting community mental health components in the teaching institutions. This programme will be operational within 5 years.

[k] On the recommendation of a Task Force, appropriate psychotropic drugs to be used at PHC level will be included in the list of essential drugs in India.

[l] Psychiatric units with in-patient beds will be provided at all medical college hopsitals in the country within 5 years.

6.2 Detailed Activities

6.2.1 Activities within the sole responsibility of the **Ministry of Health, Government of India**, which will be pre-requistes to the implementation of the National Plan.

[a] **Establishment of a National Advisory Group on Mental Health.** The suggested constitution of the group appears on page 16.

[b] Nomination of an Assistant Director General of Health Services within the Directorate General of Health Services, specifically for mental health action and who would also act as Secretary to the National Advisory Group on mental health.

6.2.2 Activities within the responsibility of the Ministries of Health of the State Governments

[a] Adoption of this National Mental Health Programme as plan of action at the State level.

[b] Appointment of one Programme Officer in their Directorate for mental health at a senior level.

[c] Creation of the post of atleast one district psychiatrist in every district.

[d] Provision of facilities to the district psychiatrist to visit the PHC physicians regularly where possible, in connection with other outreach and supervisory activities.

7. NEEDS FOR COOPERATION AND COORDINATION

7.1. The programme outlined is clearly and deliberately reaching beyond the traditional tasks of a specialized psychiatric service.

In the first instance, it is proposed to use the primary health care structure to provide basic psychiatric and mental health services. This means that at least at the grass root level of health care, metal health will be totally integrated into general **health care delivery.** A close cooperation of mental health professonals with other carriers of care is **thus imperative.**

Infact it is hoped that mental health would become an integral part of all health and welfare endeavours in our country.

7.2 A strong linkage of the programme should be with Social Welfare. In fact the split between agents of social welfare and mental health may have its roots in the artificial separation of psychological [i.e. intrapsychic] and social [i.e. communicative] phenomena. It would seem an innovative achievement if this traditional splitting of tasks could be overcome in India. The PHC physician and the district psychiatrist would then do individual as well as social [e.g. marital] counselling, and would advise at the same time a rural development committee on questions relating to a nursery school or the opening of a liquor store in the village. A social worker could bring a destitute for psychiatric consultation and a psychiatrist would refer a "complainer" to a social worker for help in his social needs.

7.3 Social behavioural and learning problems are manifesting themselves in schools. Addition of mental health inputs in the school health is likely to play a major role in thier amelioration. Teachers would therefore have to be given adequate orientation in early diagnosis of most of the common mental health problems.

7.4 Necessary links with the mental hospital and **medical colleges** have already been mentioned. They will be centres of referral for special cases as well as centres of various teaching activities. On the other side, it is hoped that the medical colleges will take advantage of the integrated mental health services to increase the community health component in their under–and post–graduate training.

In addition, they will be actively participating with ICMR and other research organisations on various research projects in the field of mental health.

7.5 The central mechanism of this co–operation will be the National Advisory Group, the formation of which will be the integral part of the programme. It will consist of representatives of all States and of the institutions and professions referred to above. It will thus be the central organ not only for cooperation between the states but also between the different professional groups and agencies, on a Central level, together with the focal point in the Dte. G.H.S. and Ministry of Health.

NATIONAL ADVISORY GROUP

CONSTITUTION

1. D.G. [Ex–Officio]–Chairman
2. Key person in Dte G.H.S.
3. Key person in I.C.M.R.
4. Key person in M.C.I.
5. Key person in Planning Commission.
6. Joint Secretary [Incharge] in Ministry of Health.
7. Joint Secretary [Incharge] in Ministry of Labour.
8. Joint Secretary [Incharge] in Ministry of Social Welfare.
9. Joint Secretary [Incharge] in Ministry of Education.
10. Joint Secretary [Incharge] in Ministry of Law.
11. Key person in University Grants Commission/Sec. University.
12. Psychiatric Association.
13. Key person from I.M.A.
14. Eminent people in the above field nominated.
15. Eminent person from Law.

It is envisaged that similar Advisory Bodies at a State level be also formed.

7.6 In view of diverse and varying level of development and health infrastructure in the country, a certain degree of flexibility will be essential in the implementation of this programme. The proposed plan needs to be reviewed periodically for evaluation of goals achieved. In that aspect the present plan should be understood as an initial statement of intent rather than a rigid blue print for all future programmes. The National Advisory Group would have the responsibility of regularly monitoring the progress of the programme

8. LEGISLATIVE REQUIREMENTS

Appropriate legislation for better implementation of the national mental health would also have to be looked into.

9. RESEARCH

One basic feature of the programme will have to be a continuous monitoring through evaluative research. Very close links with the ICMR will thus be an integral part of the programme activities. There is already a considerable commitment on the part of the ICMR task forces in the field of mental health, in general, and especially towards issues related to service research. Such issues will need considerable strengthening. Research like the actually initiated study on determinants of the outcome of mental diseases, or on illness behaviour, have a direct bearing on service delivery. An additional focus will have to be on evaluative research on the effectiveness of the programme at its different levels of functioning, from the training of the different levels of workers to the mode of service delivery by these workers once trained.

In view of the severe scarcity of resources in India, the equilibrium between research and service efforts may have to be reconsidered. Modern research requires inputs from many sources. For a major national programme like this, there would be need for bilateral and multilateral collaborative research between national and international groups.

Pursuing the rightful policy of creating a network of centres of excellence, and of research workers of excellence in the country, due consideration may have to be given to the orientation of such research efforts in the light of the overall health policy of the country which is directed towards health for all by the year 2000. Every system of medicine as practised in India should continue to conduct research in the field of mental health and exchangeviewsand research data for the mental enrichment and benefit.

SUMMARY

Summary of the National Mental Health Programme prepared by the Expert Group after its meetings held at All-India Institute of Medical Sciences, New Delhi on 2nd August, 1982 for submission to the Central Council of Health for consideration at its meeting held on 18th to 20th August, 1982.

1. India is a signatory State to the Alma Ata Declaration which envisages health for all by the year 2000 as the goal and primary health care as an approach. Health has been defined not as merely absence of disease but as a state of positive well-being-physical, mental and social. Mental health, therefore, forms an essential part of total health and as such must form an integral part of the national health policy.

2. Contrary to the popularly held belief, mental illness is widely prevalent in India and the prevalence is certainly not less than what is reported in the western countries. Further more, the figures in India are as high in rural as in the urban areas. The Indian research scientists have brought out enough evidence that atleast 10-20 per thousand suffer from severe mental illness at any given time and at least three to five times that number suffer from other forms of distressing and socio-economically incapacitating emotional disorders. It has also been shown that 15-20% of the people who visit general health services such as a medical out-patient department or of private practitioner or a primary health care centre have in fact emotional problems appearing as physical symptoms.

3. With the help of the Government of India and the WHO, a series of meetings were arranged with specialists in the field of mental health as well as experts in education, social welfare, law, labour and leaders engaged in various national developmental programmes. As a result of these meetings, a proposal for national mental health programme for the country has been formulated. This programme has been designed keeping in view the magnitude of mental health problem in the country, existing resources, both human and material, advances in the mental health technology particularly in the field of delivery of health care to the people in the rural and far flung areas and outcome of research studies in various fields. Under this programme, it is envisaged that at least 200 million people particularly belonging to the socially and economically backward areas of the country are likely to benefit.

4. The programme thus has been formulated with the following objectives:

   a. to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of population.

   b. to encourage application of mental health knowledge in general health care and in social development.

   c. to promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

5. In order to achieve the above objectives, the programme has been designed to have the following approaches:

a. Integration of the mental health care service with the existing general health services;

b. to utilise the existing infra-structure of health services and also to deliver the minimum mental health care service;

c. to provide appropriate task oriented training to the existing health staff;

d. to link mental health services with the existing community development programme.

6.1 The programme will have three components, namely, treatment, rehabilitation and prevention of illness and promotion of positive mental health. The treatment programme has been planned keeping the primary health care approach as the sheet-anchor. At the same time, it consists of the creation of an appropriate referral system at various levels. It is proposed that the specialised psychiatric services should be made available at the district level. The other major responsibilities for the health personnel at the district level would be to provide training and supervision to the workers at the primary health centre level. The mental hospitals, medical colleges, teaching institutions and mental institutes shall also be linked together into the national grid for the mental health care particularly in the field of education and research.

6.2 The rehabilitation sub-programme will develop services for the rehabilitation of the chronically disabled both due to mental illness as well as mental retardation. This programme envisages linkages with the rehabilitation programme of other Ministries particularly the Ministries of Labour and Social Welfare.

6.3 In the field of prevention and promotion, the sub-programme visualises counselling services for common mental health problems like alcohol and drug abuse, delinquency and genetically inherited mental illness.

7. An exercise has also been done in order to identify the various targets that would have to be attained in a time-bound frame. It is proposed that a small Co-ordinating Group at the Centre be formed immediately which would go into the phasing of the programme.

8. The salient recommendations for futher action are as under:

a. Mental health must form an integral part of the total health programme and as such be included in all national policies and programmes in the field of health, education and social welfare.

b. Considering the importance of mental health in the total development of society, mental health aspects should be kept in view in the planning of activities for national development.

c. Appreciating the importance of mental health in the course curriculae for various levels of health professionals, suitable action should be taken with the appropriate authorities to strengthen the mental health educational component.

d. The practitioners of Indian systems of medicine should continue to play their respective distinct roles in the field of health inclusive of mental health.

9. The above recommendations are commended for consideration by the Central Council of Health. Keeping in view the importance of mental health as an integral part of the total health, the Central Council of Health may kindly lend its support for adoption of the programme.

RECOMMENDATIONS OF THE CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE

Recommendations made by the Central Council of Health and Family Welfare on Mental Health Programme in its meeting held on 18th to 20th August, 1982 are as follows:

The Joint Conference considered the importance of mental Health in the total development of society and appreciated that mental health is an integral part of total health and it should therefore be viewed in that light. The Joint Conference recommends that:

(i) Mental health must form an integral part of the total health programme and as such should be included in all national policies and programmes in the field of Health; and Education and Social Welfare.

(ii) Realising the importance of mental health in the course curriculae for various levels of health professionals, suitable action should be taken in consultation with the appropriate authorities to strengthen the Mental Health Education components.

While appreciating the efforts of the Central Government in pursuing legislative action on Mental Health Bill, the joint Conference expressed its earnestness to see that the bill takes a legal shape at the earliest.

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EPILOGUE

Now we have come to the stage as to how best the resolution passed by the Central Council of Health, the country's highest policy making body on Health, can be translated into a reality and towards this end we have to got the whole hog for achieving the desired goal of absorbing mental health as an integral part of the total health framework of the country and its inclusion in all national policies and programmes in the field of Health, Education and Social Welfare as also utilising the line of action as reflected in the Resolution as an intermediate means for fructifying the goal of "Health for All by 2000 A.D."

As a first practical step, the Ministry of Health and Family Welfare, Govt. of India, have impressed upon the Governments of all the States/Union Territories to implement the Resolution of the Central Council of Health on the Mental Health Programme and the progress of implementation would be monitored through "Action Taken Reports" received from the States/Union Territories.

Depending upon the difficulties and bottlenecks encountered by the various implementing agencies, corrective measures will be evolved/adopted for the smooth and result-oriented functioning of the Mental Health Programme.

The Mental Health Bill is already on the anvil of the Parliament and every effort is being made by the Central Government to ensure that the bill takes a legal shape at the earliest.

APPENDIX I

MEMBERS OF THE MENTAL HEALTH WORKING GROUP AND DRAFTING COMMITTEE FOR NATIONAL MENTAL HEALTH PROGRAMME FOR INDIA: 1981-82

1. Dr. D.B. Bisht,
   Director General of Health Services,
   Nirman Bhavan, New Delhi.
2. Dr. N.N. Wig,
   Prof. of Psychiatry,
   All-India Institute of Medical Sciences,
   New Delhi.
3. Dr. B.B. Sethi,
   Prof. & Head,
   Dept. of Psychiatry,
   K.G. Medical College, Lucknow.
4. Dr. A. Venkoba Rao
   Prof. & Head,
   Dept. of Psychiatry,
   Medical College, Madurai.
5. Dr. Pande/Dr. S.D. Sharma,
   Director,
   Central Institute of Psychiatry,
   Ranchi.
6. Dr. R.L. Kapur,
   Prof. of Community Psychiatry,
   National Institute of Mental Health
   and Neuro Sciences,
   Bangalore.
7. Dr. H.L. Sell,
   Adviser in Mental Health,
   SEARO,
   World Health Organization,
   New Delhi.

APPENDIX II

LIST OF THE PARTICIPANTS TO 1ST WORKSHOP OF THE NATIONAL MENTAL HEALTH PROGRAMME FOR INDIA

Date: July 20–21, 1981
Venue: All-India Institute of Medical Sciences, New Delhi-110029
Convenor: Dr. N.N. WIG

1. Dr. B.R. Agnihotri, New Delhi
2. Dr. R. Anand, Lucknow.
3. Dr. Mohan Agashe, Pune.
4. Dr. Dipesh Bhagwati, Gauhati.
5. Dr. Jagdish Batla, Karnal.
6. Dr. B.H. Buch, Ahmedabad.
7. Dr. D.B. Bisht, New Delhi.
8. Dr. V.K. Bhat, Varanasi.
9. Dr. A. Chakraborty, Calcutta.
10. Dr. H.M. Chawla, New Delhi.
11. Dr. [Mrs] P.L. Chawla, New Delhi.
12. Dr. E. Chander, Ludhiana.
13. Dr. Channabasavanna, Bangalore.
14. Dr. Jiban Chakraborty, Agartala.
15. Dr. B. Dash, Cuttack.
16. Dr. S. Dube, New Delhi.
17. Dr. Satyawati Devi, New Delhi.
18. Dr. K.C. Dube, Agra.
19. Dr. D. Dutta, Gauhati.
20. Dr. Shiv K. Sharma Gautam, Jaipur.
21. Mr. Surya Gupta, New Delhi.
22. Dr. Mohan Issac, Bangalore.
23. Dr. Jindal, New Delhi.
24. Dr. K. Krishna Murthy, Hyderabad.
25. Dr. Raj Kumar, Madras.
26. Dr. Ravi Kapoor, Bangalore.
27. Dr. S.C. Mullick, New Delhi.
28. Dr. Yogendra Mohan, Simla.
29. Dr. D.K. Menon, New Delhi.
30. Dr. D. Mohan, New Delhi.
31. Dr. R.S. Murthy, Chandigarh.
32. Dr. G.C. Munjal, New Delhi.
33. Dr. D.N. Nandi, Calcutta.
34. Dr. L.M. Nath, New Delhi.
35. Dr. V.S. Rastogi, New Delhi.
36. Dr. Raghu Ram Reddy, Hyderabad
37. Dr. V. Ramachandran, Madras.
38. Dr. Gurmeet Singh, Patiala.
39. Dr. A.V. Shah, Ahmedabad.
40. Dr. L.P. Shah, Bombay.
41. Dr. Shridhar Sharma, Goa.
42. Dr. Somasundaram, Madras.

43. Dr. R.P.N. Singh, Patna.
44. Dr. Halmut Sell, W.H.O.
45. Dr. Sandi Syiem, Shillong.
46. Dr. B.B. Sethi, Lucknow.
47. Dr. H.L. Sharma, Amritsar.
48. Dr. S. Trivedi, Pondicherry.
49. Dr. B.K. Jha, Delhi.
50. Dr. V.N. Vahia, Bombay.
51. Dr. Varshney, New Delhi.
52. Dr. A. Varghese, Vellore.
53. Dr. V.K. Varma, Chandigarh.
54. Dr. N.N. Wig, New Delhi.
55. Dr. J.N. Vyas, Bikaner.
56. Dr. A. Venkoba Rao, Madurai.
57. Group—Captain K.R. Banerjee, New Delhi.
58. Lt Col. V.K. Pande, New Delhi.
59. Dr. S. Bhatnagar, New Delhi.
60. Dr. S. Santhakumar, Calicut.
61. Dr. V.R. Deo, Pune.
62. Dr. G.C. Boral, Calcutta.
63. Dr. A.L. Kumar, New Delhi.
64. Dr. B.S. Yadav, Agra.
65. Dr. N. Kezieno, Nagaland.
66. Dr. Veeraraghavan, New Delhi.
67. Dr. L. Priyokumar Singh, Manipur.
68. Dr. Prabhakaran, Trivandrum.

APPENDIX III

LIST OF THE INVITEES,PARTICIPANTS TO THE 2ND WORKSHOP OF THE NATIONAL MENTAL HEALTH PROGRAMME FOR INDIA

Date: 2nd August 1982
Venue: All-India Institute of Medical Sciences, New Delhi-110029
Convenor: Dr. N.N. Wig

1. Dr. R.M. Varma,
   Emeritus Professor,
   National Institute of Mental Health &
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2. Dr. [Mrs.] Usha K. Luthra,
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   Indian Council cf Medical Research,
   New Delhi.
3. Prof. D.N. Nandi,
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4. Prof. B.B. Sethi,
   23, Ashok Marg,
   Lucknow Pin 226001.
5. Prof. V.N. Bagadia,
   Palmspring Premises Society, near Chandan Cinema,
   Ville Parle, Bombay Pin 400054.
6. Prof. A. Venkoba Rao,
   Professor of Psychiatry,
   Madurai Medical College,
   Madurai-13, Tamil Nadu.
7. Prof. S.D. Sharma,
   Director,
   Central Institute of Psychiatry,
   P.O. Kanke, Ranchi Pin 834006.
8. Dr. G.G. Prabhu,
   Prof. & Head,
   Dept. of Cl. Psychology,
   National Institute of Mental Health & Neuro Sciences,
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9. Prof. Abraham Verghese,
   Mental Health Centre,
   Christian Medical College Hospital.
   Vellore-2.
10. Dr. Gurmeet Singh,
    Prof. & Head, Dept. of Psychiatry,
    Govt. Medical College & Rajendra Hospital,
    Patiala Pin 147001.

11. Dr. A.B. Khurana,
Prof. of Psychiatry,
Medical College & SSG Hospital,
Baroda–390001.
12. Dr. Paul Choudhry,
Director,
National Institute of Public Cooperation &
Child development,
Siri Institutional Area, Haus Khas,
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13. Dr. R. Srinivasa Murthy,
National Institute of Mental Health & Neuro Sciences,
Post Bag No. 2979, Bangalore Pin 560029.
14. Dr. U.B. Krishnan,
Secretary,
Medical Council of India,
Kotla Road, New Delhi.
15. Prof. N.N. Wig,
Head of the Dept. of Psychiatry,
All–India Institute of Medical Sciences,
New Delhi.
16. Smt. Madhu Ben Shah Representative
Chairman,
University Grants Commission,
Bahadur Shah Zafar Marg,
New Delhi–110001.
17. Shri U. Vaidyanathan,
Adviser [Health]
Planning Commission,
Yojana Bhavan,
New Delhi.
18. Shri S.K. Bahadur,
Joint Secretary & Legal Adviser,
Ministry of Law & Company Affairs,
Shastri Bhavan, New Delhi.
19. Shri M.C. Narasimhan,
Joint Secretary,
Ministry of Social Welfare,
Shastri Bhavan, New Delhi.
20. Shri R.K.A. Subrahmanya,
Addl. Secretary,
Ministry of Labour,
Shram Shakti Bhavan, New Delhi.
21. Dr. A.V. Shah,
President,
Indian Psychiatry Society,
Dept. of Psychiatry,
B.J. Medical College, Ahmedabad.

22. Dr. R.N. Chatterjee,
President,
Indian Medical Association,
1518 Wright Town, Jabalpur [M.P.]
23. Dr. H. Sell,
W.H.O., SEARO, New Delhi.
24. Dr. G.N. Narayana Reddy, Director,
National Institute of Mental Health & Neuro Sciences
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25. Dr. R.L. Kapur,
Professor, Community Psychiatry,
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26. Dr. D.K. Menon,
Indian Council of Medical Research,
New Delhi.
27. Dr. D. Mohan,
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New Delhi.
28. Dr. Ajita Chakraborty,
Prof. of Psychiatry,
Institute of Post-graduate Medical Education
& Research,
Calcutta.
29. Dr. L. Ramachandra,
Director,
Gandhigram Institute of Rural Health &
Family Welfare,
Madurai.
30. Dr. A. Zahra,
Programme Co-ordinator,
W.H.O., New Delhi.